PROOF OF CLAIM IN THE MATTER OF
Tufts Health Plan of New England, Inc.

Read Carefully Before Completing This Form

Please print or Type

Deadline for Filing this Form is July 10, 2000.

FOR COMPANY USE ONLY

DATE PROOF OF CLAIM RECEIVED

LIQUIDATOR'S POC #

You have been identified as someone who might have a claim against Tufts Health Plan of New England, Inc. You have a claim if you know or believe Tufts Health Plan of New England, Inc. owes you money. *You should complete this form if you believe you have an actual or potential claim against* Tufts Health Plan of New England, Inc. To have your claim considered by the Liquidator, this Proof of Claim must be received by Tufts Health Plan of New England, Inc. no later than July 10, 2000. Failure to return this completed form will result in the DENIAL OF YOUR CLAIM. You are advised to retain a copy of this completed form for your records.

1. Claimant's Name: _____

2. Claimant's Address: _____

_____

3. Claimant's Telephone Number, with area code: _____
Fax Number, with area code: _____

4. Claimant's Social Security Number, Tax ID Number or Employer ID Number: _____

5. Claim is submitted by (check one):

a) ___Policyholder of Tufts Health Plan of New England, Inc. (Individual or employer group making premium payment to Tufts Health Plan of New England, Inc. for healthcare)
b) ___Member or Subscriber with a claim for unreimbursed medical services
c) ___Medical Provider, Enter Tufts Health Plan of New England Provider Nr _____
d) ___Broker or Agent licensed with Tufts Health Plan of New England, Inc.
e) ___General Creditor of unpaid invoices
f) ___State or Local Government Entity Describe in detail the nature of your claim and attach supporting documentation:
_____
_____
g) ___Other. Describe in detail the nature of your claim and attach supporting documentation:
_____
_____

6. Indicate the total dollar amount of your claim. If the amount of your claim is unknown, write the word "unknown", BUT be sure to attach sufficient documentation to allow for determination of the claim amount.

$_____ (if amount is unknown, write the word "unknown").

Do you claim a priority for your claim? If so, why: _____
_____

Is there any dollar amount which should be deducted by Tufts Health Plan of New England, Inc. from your claim (e.g. premium owed by you to Tufts Health Plan of New England, Inc.) or any other reason your claim should not be paid in full? If so, describe in detail: _____
_____

If you have obtained a judgement against Tufts Health Plan of New England, Inc. on which you are basing your claim, please complete Section 13.

Has Tufts Health Plan of New England, Inc. paid any part of your claim? YES____ NO____

If YES, please complete the following UNLESS the partial payment was for reimbursement of medical services that you provided or paid for.

Amount of partial payment _____
Date of partial payment _____

7. If you were a Tufts Health Plan of New England, Inc. policyholder and are submitting a claim based on unearned premium, describe in detail the nature of your claim, including the date(s) for which you paid for coverage that was not provided due to the termination of your policy. Attach all relevant documentation in support of your claim such as copies of premium statements that you paid.

_____

_____

8. If you are a medical provider and have a claim for services provided or other amounts related to providing covered services that have not been paid due to the liquidation of Tufts Health Plan of New England, you must provide the following information in support of each claim. A detailed listing of your receivables is required. This listing must include a) the member identifier or subscriber's social security #, b) patient's name, c) date of service, d) procedure code or other service identifier and e) the dollar amount of the services. Documentation supporting other types of claims related to the provision of medical services under a contractual arrangement must also be submitted, such as copy of the applicable provider services agreement.

9. If you were a Tufts Health Plan of New England, Inc. member or subscriber filing for medical services reimbursement, you must provide the following information for each claim. You may attach a separate sheet if necessary. You must provide documentation to support your claim (i.e. copy of provider's billing statement and/or claim form (e.g. HCFA 1500 or UB-92)).

a. Member # (Social Security # of Subscriber): _____ - ____ - _____
b. Patient's name: _____
c. Date of claim: _____
d. Dollar amount of claim: _____

10. If you are a general creditor, describe, in detail, the nature of your claim, including the amount of any security backing up your claim. Attach all relevant documentation in support of your claim, such as copies of outstanding invoices or applicable contracts:

_____

_____

11. Print the name, address and telephone number of the person who has completed this form.

Name: _____
Address: _____
_____
Phone # with Area Code (_____) _____ Email address _____

12. If represented by legal counsel, please supply the following information:

a. Name of attorney: _____
b. Name of law firm: _____
c. Address of law firm: _____
_____
d. Attorney's telephone: _____
e. Attorney's fax number: _____
f. Attorney's email address _____

13. For completion by a claimant using a judgement against Tufts Health Plan of New England, Inc. as the basis for this claim:

a. Amount of judgement _____
b. Date of judgement _____
c. Name of case _____
d. Name of court _____
d. Court docket or index number (if any) _____
e. State court is located in _____

14. Complete the following:

I, _____ (insert claimant's name) subscribe and affirm as true, under the penalty of perjury as follows: that I have read the foregoing proof of claim and know the contents thereof, that this claim in the amount of _____ DOLLARS ($_____) against Tufts Health Plan of New England, Inc. is justly owed, and except as stated in item 6 above with respect to a setoff to be deducted from my claim, there is no defense or counter-claim to my claim, and that the matters set forth above or in any accompanying statements are true to the best of my knowledge and belief. I also certify that no part of this claim has been sold or assigned to a third party.

_____ _____
Claimant's signature Date

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

15. Return this completed Proof of Claim Form by **July 10, 2000** to:

Proof of Claim Form
Tufts Health Plan of New England, Inc.
PO Box 549237
Waltham, MA 02454-9237

You should complete this form if you believe you have an actual or potential claim against Tufts Health Plan of New England, Inc.